Independent Medical Examiner
Application For Appointment

Nebraska Workers' Compensation Court
State Capitol Building
P. O. Box 98908
Lincoln, NE 68509-8908

402-471-6468 or 800-599-5155
402-471-2700 (FAX)
http://www.wcc.ne.gov/

Applicant's Name:		Social Security Number:	Date of Birth:
Address:		City or Town:	
State:	Zip Code:	Business Telephone:	

EDUCATION AND TRAINING

Name & Location	Dates From/To	Major	Degree	Month/Year of Degree
College/University:				
Medical School:				
Osteopathic School:				
Chiropractic School:				
Other:				

PROFESSION

Specialty:	Subspecialty:
Board certification with:	Board certification with:
Certification expires: _____	Certification expires: _____

Have you ever performed an independent medical exam? Yes ❑ No ❑ If yes, how many years have you been performing IMEs? _____

What percentage of current practice is IMEs?

List any IME training you have attended:

Please list any experience or education concerning workers' compensation principles or the Nebraska workers' compensation system:

Please identify any employer, insurer, attorney, employee group, managed care plan or representatives of any of these to whom you are under contract or who regularly use your services:

If appointed, what type of cases would you prefer be referred to you?

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Nebraska State License # _____ Tax I.D. # _____ Drug Enforcement Agency # _____

Are you currently licensed in any other state? Yes ☐ No ☐ If yes, please list state and license #: _____

List any other registrations, certifications or licenses you possess: _____

Have you ever been subject to disciplinary action? Yes ☐ No ☐ If yes, please explain: _____

Have you ever voluntarily surrendered your license? Yes ☐ No ☐ If yes, please explain: _____

PRACTICE HISTORY

Present practice name and location:

Name: _____ Type of Practice: _____ From: _____

Address: _____

List other site addresses if applicable: _____

Prior practice name(s) and location(s):

1. Name: _____

   Address: _____ Telephone: _____

   City, State & Postal Code: _____ From: _____ To: _____

2. Name: _____

   Address: _____ Telephone: _____

   City, State & Postal Code: _____ From: _____ To: _____

3. Name: _____

   Address: _____ Telephone: _____

   City, State & Postal Code: _____ From: _____ To: _____

I request appointment to the list of independent medical examiners maintained by the Nebraska Workers' Compensation Court. I will provide independent, impartial and objective medical findings in all cases that come before me. I will decline a request to serve as an independent medical examiner only for good cause shown. I will conduct an examination, if necessary, within 28 calendar days from notification of assignment. I will submit a written report within seven calendar days following receipt of all necessary records and information, the completion of an examination, or the completion of any required tests, whichever is applicable. I will accept the fees established pursuant to Rule 65 as payment in full for services rendered as an independent medical examiner. I will submit to a review pursuant to Rule 62, E.

I have read and understand Rule 62 though Rule 66 of the Nebraska Workers' Compensation Court, which describe the independent medical examiner system. I agree to comply with all of the provisions of these rules.

I hereby attest that the information contained in this application is correct to the best of my knowledge and belief. I understand that false or misleading information may result in the rejection of my application or in my removal from the list if I am appointed.

SIGNATURE _____ DATE _____